Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DIAGNOSTIC IMAGING INSTITUTE P.O. BOX 743125 DALLAS, TX 75374	MFDR Tracking #:	M4-07-7314-01
Respondent Name and Box #: FIDELITY & GUARANTY INSURANCE REP. BOX #: 19		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "Requested test for Designated Dr. exam. Does not count toward FCE maximum."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $426.12
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines and whether the documentation provided supports the level of services. All reductions of the disputed charges were made appropriately…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
07/13/06	CPT Code 97750-FC ($28.41 x 125% = $35.51 x 12 units = $426.12	1 – 6	$426.12
Total:			$426/12

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "W11 – Entitlement to benefits. Not finally adjudicated."

2. A Benefit Review Conference was held on January 25, 2007, to medicate resolution of the disputed issues, but the parties were unable to reach an agreement. A Benefit Contested Case Hearing was held on March 29, 2007 in favor of the claimant. The decision of the Hearing Office documents that the claimant sustained a compensable right hand tendonitis injury in the form of an occupational disease on December 20, 2005. Therefore, the disputed date of service will be reviewed in accordance with the statute and rules seffective at the time the services were rendered.
3. Per Division Rule at 28 TAC Section 133.307(j)(2) defenses brought up in the summary of the Carrier's position statement pertaining to "whether the charges are consistent with applicable fee guidelines and whether the documentation provided supports the level of service" were raised after the filing of to Medical Fee Dispute Resolution.
4. According to the submitted Functional Capacity Evaluation (FCE), the claimant was referred to Diagnostic Imaging Institute, Inc. by the designated doctor Wayne Soignier, MD. The FCE report documents the state time as 9:30 am and the end time as 12:30 pm. According to the CMS-1500 12 unites (4 hours) were billed. Therefore, per 28 TAC Section 134.202(e)(4) and 134.202(c) reimbursement is recommended.
5. Per review of Box 32 on CMS-1500, zip code 76708 is located in McLennan County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 133.307, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $426.12 plus applicable accrued interest per Division Rule 134.130 (use Rule 134.803 for dates of service prior to 5/2/06), due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution	August 24, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.